Every Woman Matters

NEBRASKA OFFICE OF WOMEN'S HEALTH

Client Informed Refusal

Version: 6-2005

Every Woman Matters
P.O. Box 94817
Lincoln, NE 68509-4817

Client Name _____ DOB: _____

SSN#: _____ Name of Procedure/Treatment: _____

Date _____/_____/_____

I, _____ have been informed by my doctor/health care giver,
(please print your name)
that I should have this procedure/treatment below. This procedure is: _____

_____.
(please print in your own words, the name of the procedure/treatment and why it is being done)

If I do not get this procedure/treatment I know these things will happen to me:_____

_____
(please print in your own words what can happen if the procedure/treatment is not done)

- ■ I have had the need for this procedure/treatment explained to me.
- ■ I know that not having this procedure/treatment at this time, is against my doctor's advice and may be harmful to my health. My abnormality may lead to cancer if I do not have it done.
- ■ I know what this procedure/treatment is for. I know why I need it. I know how it is done.
- ■ I know that signing this form does not stop me from having this procedure/treatment done later.
- ■ I know how to get money to help me pay for the procedure/treatment.
- ■ I know that I am still a part of Every Woman Matters (EWM) if I am over forty years of age.
- ■ I know that I can reapply later to EWM if I am under 40 years of age.
- ■ I have read all the information above and know what it means. I am choosing to refuse the above procedure/treatment at this time.

Client Signature _____ Date _____/_____/_____

Submitted by:
- ❑ Clinic
- ❑ Outreach Worker
- ❑ Case Manager
- ❑ EWM Central Office

_____
Name of Submitting Facility/Clinic/Agency

Portion below to be completed only if client unable to write or has language barrier.
If client unable to write inforamtion herself; the client will dictate the information and the form should be signed by two individuals.

Dictated by _____ Date _____/_____/_____
Please Print Client Name

Written by_____ Date _____/_____/_____
Person taking the dictation

Witnessed by:

1. _____ Date _____/_____/_____

2. _____ Date _____/_____/_____

Interpreted by: _____ Date _____/_____/_____
If Interpreter Needed

Complete reverse side only if unable to obtain a signed Client Informed Refusal

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Service Provider Documentation

Nebraska Office of Women's Health

Version: 6-2005

Provider has insured that the client has enough information to make an informed decision.

Client Informed Refusal given to client:
- ❑ In person
- ❑ Mail

Client failed to return a signed Client Informed Refusal.

_____ Date _____/_____/_____

Name of Facility/Clinic/Agency

Attempts were made to give information to the client regarding:
- ❑ Diagnostic Services
- ❑ Diagnosis
- ❑ Treatment Services
- ❑ Treatment

Provider is unsure if the client has or is able to make an informed decision due to one or more of the following reason(s):

- ❑ No verbal communication with client
- ❑ Low literacy level
- ❑ Language / Translation issues
- ❑ Mental / Emotional disability
- ❑ Visual / Hearting impairment

_____ Date _____/_____/_____

Name of Facility/Clinic/Agency